MIHP Design Workgroup Meeting

October 4, 2005

Present: Bonnie Ayers, Dianna Baker, Mark Bertler, Ann Bianchi, Lynette Biery, Sandra Brandt, Alethia Carr, Ingrid Davis, Paulette Dobynes Dunbar, Stacey Duncan-Jackson, Sheila Embry, Brenda Fink, Judy Fitzgerald, Susan Gough, Mary Ludtke, Deb Marciniak, Phyllis Meadows, Jackie Prokop, Diane Revitte, Tom Summerfelt, Betty Tableman, Jackie Wood, Betty Yancey.

By phone: Patricia Fralick, Darlene VanOveren, Belinda Bolton, Carolyn Rowland, Sharifa Aboumediene.

Tasks

1. Lynette will email the integrated MIHP/WIC integrated prenatal screening tool to Alethia, Brenda, and Jackie, for their review and comment.
2. Tom will post the literature citations confirming the standard cutoff scores for the Edinburgh Postpartum Depression Scale on the MIHP web site. DWG members will get an email indicating that this info has been posted.
3. Lynette will send the infant screener draft to the DWG next week, and it will be posted it on the MIHP web site soon thereafter.

Draft Findings from the Michigan Families Medicaid Project (MFMP) Year Two

The PowerPoint slides Tom Summerfelt and Lynette Biery are about to present are at www.ihcs.msu.edu/mfmp/default.htm, along with other MFMP documents, including their FY 05 project report. The bulk of MFMP activities in FY 05 were related to the maternal screener, but they also extracted data from state agencies and did a 2003 cohort analysis on pregnant Medicaid beneficiaries, similar to the one they did last year based on 2001-2002 data. Some of the data from the 2003 analysis are included in the today's slides.

Tom said that DWG members are familiar with Lynette and him, but it's important to acknowledge the work of Lee Ann Roman and the other folks on the MFMP leadership team.

Tom described the population-based model and said that today we're focusing on the first 3 components: population identification/access; screening/assessment; risk stratification.

MFMP was able to add WIC data to the 2003 cohort analysis that weren't previously available, so the data set is more complete. Level of risk remained fairly stable across the three years studied; inclusion of the additional data resulted in only a few risk changes. One change was that the Kotelchuck Index (measures adequacy of prenatal care) worsens. We need to track this over time to see if this is a blip or a trend. It was suggested this might be a result of identifying more Hispanic women, as they tend use

emergency medical services only. It may be useful to do a sub-analysis of Hispanic and migrant women.

The three pilot sites used different workers to conduct the maternal screener interviews: Genesee used community health workers (parapros); Kent used WIC staff; District 10 used MSS/ISS staff (nurses and social workers). Tom thanked the workers at all three sites for tolerating a great deal of ambiguity and being very understanding throughout the pilot phase.

In all cases, the screener was administered by trained staff – it was not intended for self-administration. It took about 20 minutes to do the MIHP version, and about 40 minutes to do the integrated MIHP/WIC version.

After the screener was administered, consumers were asked a series of reactivity questions. Generally, they liked the screener, and thought it was easy to understand, complete and straightforward. They commented on the professional nature of the interviewers, including the parapros. They most often said they had no suggestions for making the screener easier or for changing it, although some said it's long, and some said there were duplicate questions (probably referring to the Kent Co. integrated screener - it had a few questions that were similar but that couldn't be changed because they were taken from a standardized tool or federally mandated by WIC, PIMS, etc.).

Staff in WIC ended up liking the screener because women were more willing to talk, allowing staff to uncover risks that weren't previously identified. It also "opened the door" for providing education. Diana said that in Kent Co., they served a woman who had a substance abuse problem - the "old" assessment tool had not picked up on it, but the new one did.

Will the interview flow as well when interviewers have to enter responses electronically rather than check them off with paper and pencil? Because of the programming problems we've had with the electronic format, we don't know yet know how consumers and staff will like it once we get it operating correctly, but we think they will like it. Some agencies have loaded the current tools onto tablets and people appear to be comfortable with this.

Judy noted that if providers start using the new screener in November, they'd soon have a huge pile of data that someone is going to have to enter. Lynette said that Michigan Families Medicaid Project (MFMP) will sign you up for the study and enter the data for you, if you agree to get consent to participate from your clients.

The Kent Co. experience suggests that it may take an extra 15 minutes to use the integrated tool with an interpreter. MFMP has translated the tool, but it hasn't been tested yet.

Risk Data

On the day they were screened, 25% of the cohort said they continued smoking when they when they found out they were pregnant, and 18% said they quit. Some DWG members thought this was under-reported; many women say they quit at first, but then they start up again.

66% of the cohort got the full Edinburgh Postpartum Depression Scale (EDPS), based on their answers to the two US Health Service depression questions (three questions for African American women). A score of 13 or higher on the EDPS indicates severe depression; 10 – 12 moderate depression; and less than 10, mild depression. It was suggested that these are not the correct cut-offs for mild, moderate and severe, but Tom checked, and found these were the standard cut-offs in the literature. He will post the citations confirming this on the MIHP web site. DWG members will get an email indicating that this info has been posted. 51% of the cohort were severely depressed, 35% were moderately depressed, and 14% were mildly depressed.

There were several stress questions on the screener – we need to have fewer of them. All of the women reported they have social support; 60% say they get it from the baby's father, some say they get if from their mom or sister.

There was discussion around the periodontal disease slides. Dr. Ramirez at WSU is one of the leaders who believes that there's a connection between periodontal disease and pre-term births, but some are skeptical that this will be borne out in literature, given all of the confounding variables.

As has been found in other studies, community health workers (paraprofessional peers) are valuable – they do well with establishing rapport and trust. However, they do need extra training and ongoing support for their own well being. The wanted to leap into action and help the women they screened, when this was not always part of their role. Using community health workers to conduct screenings provides a phenomenal opportunity for consumers to move into paying jobs.

MIHP/WIC Integrated Screener

Because it is the pilot site for the integrated screener, Kent Co. WIC has special approval to use the screener and be reimbursed for it. Dianna said some of the lessons learned from the Kent Co. pilot are:

- Initial concern about the extra 20 minutes it takes to ask the MIHP questions has decreased tremendously – it's not a big deal. We're meeting next week to logistically figure out how to do use the integrated screener in 3 of our 5 Kent County WIC sites.
- Duplication of services occurs because we don't have the database yet. WIC did screens on some women that MSS had already assessed because someone else had already referred them. The first provider to bill for the service gets paid for it.

Can Kent County's integrated tool be shared across the state for use in communities that have already integrated WIC and MSS/ISS? Pat (Northwest Michigan) and Bonnie (Mid-Michigan) said they have cross-trained staff and have the billing mechanism in place, but need the state's blessing to use the integrated screener. Pat noted that every time WIC or MSS/ISS changes forms, she has to get both systems to approve her agency's integrated forms, and that it's not realistic to have each local agency doing this individually. The state needs to make it happen.

After considerable discussion, it was concluded that the integrated screener is not ready to be shared at this point, because it has not been reviewed and approved by WIC, the Division of Family & Community Health, and Medicaid. Alethia noted that WIC had been waiting to hear the results of the pilot study to use as the starting point. The state does not want to keep communities from moving forward with integration, but needs to do some additional work internally before the tool can be issued. Lynette will email the integrated tool to Alethia, Brenda, and Jackie, for their review, feedback and approval.

Pat asked if the agencies that have already done the integration work and are ready to go, could become pilot sites so they can use the integrated screener. Lynette said yes - that if Pat would get consent from their women to participate in the study, the MFMP would love it.

Some of the logistical issues that have to be resolved are:

1. *Setting up the reimbursement system for WIC providers*. WIC providers cannot be paid for administering the integrated screener at this point because they are not Medicaid providers. Will WIC be required to become a Medicaid provider? Could policy state that WIC staff with certain credentials can administer the screen without WIC having to become a Medicaid provider? WIC offices that want to screen would need to have affiliation agreements with the existing MIHP providers to ensure that efforts are coordinated, so both are not trying to bill for screens that were administered to the same woman.
2. *Determining which credentials WIC staff will be required to have in order to administer the screener*. The credentials that nutritionists will be required to have will make a huge difference to WIC. Initially, only MIHP staff will be authorized to use the new screener.
3. *Streamlining the integrated screener to minimize duplication of items*. A few of the women in the pilot study said there was duplication of some items on the screener. Lynette said that only 2 of 220 women commented on this, and that she can go back and check – they may not even have been from the Kent site where the integrated form was used. MDCH will review and streamline the integrated screener by combining questions, whenever possible, so we aren't asking the same question repeatedly, with slightly different thrusts. This may not be possible in some cases because the federal government requires specific language on certain WIC questions and we don't want to change MIHP questions that are literature-based. Alethia said that the WIC risk codes are changing and we need to wait until the new codes are incorporated in the health history. Jackie said that

from Medicaid's perspective, the two forms can be integrated, as long as all of the Medicaid questions are included.

4. *Coordinating efforts where there are multiple providers*. Judy said that Intercare has WIC programs in several counties, and that MSS/ISS providers are asking the WIC coordinators what the new, integrated set up will be. Intercare is telling them that we're waiting to hear what the state WIC office will say. Providers think the integration begins Nov. 1. It's being said that MIHP should be working with WIC, but WIC doesn't know how to proceed. Judy said that at our last DWG meeting, it was stated that a joint letter was going out explaining everything, and it's very important for the state do this. Brenda reiterated that this first phase doesn't include WIC billing Medicaid. Ingrid said that Diane, Ingrid, and Deb have been meeting with WIC and MIHP staff in Southeast Michigan to gather info so we can figure out the details of integration. We think if we can do it in large urban settings, we can do it anywhere. Lynette suggested talking with Macomb (their WIC office did an "MSS provider of the month" referral arrangement) and Genesee Counties. Brenda said integration is very complex. We're starting these discussions at local level and will be developing guidelines.
5. *Training WIC providers to administer the new screener*.
6. *Getting buy-in from health officers for WIC to administer the new screener*.

Update on Proposed Medicaid Policy Draft on New/Revised MSS Screening Tool, Assessment Form, and Care Plan

Jackie said the effective date for the new policy has been changed from Nov. 1 to Dec. 1. Policies always go into effect on the first day of the month. Providers will have 6 weeks rather than one month to gear up for the changes once they have seen the final policy. Public comments did not result in many changes – most comments were suggestions for edits or future program changes.

Tom said that if we want to keep the MIHP current with the changing literature, we will need agility in modifying policy as we go along, especially as we introduce risk stratification and case rates. We need the ability to move quickly. Jackie said that slight changes won't require policy modifications – we can use other mechanisms in some cases. Brenda said that moving swiftly is the whole point to CQI and that we need to be fleet-footed in the appropriate way.

MIHP Workgroup Updates

<u>MIHP Data System WG</u>: This WG has been revamped with Cynthia Edwards and Alethia Carr co-chairing. There was a meeting yesterday to discuss data elements for the registry and how to move forward. WIC is upgrading its data system and is looking to link it to the MIHP data system. It's a good time to interface to decrease duplication. We have a cost estimate on a data system based on the long-term care model and it's reasonable. Jackie said a big topic of discussion at the meeting was identifying all the data bases in various systems that need to be linked and determining where all the data will be housed. There was also discussion around a tool to allow providers to submit

outcome data after the woman delivers her baby. The warehouse is a virtual registry, not a free-standing registry. It's "nimble", allowing us to pull from various sources. We will look at program administration data and identify what data is needed by providers at the desk level vs. what data is needed by counties and the state. Brenda said this is complicated, and different issues will come out as we go down the path, but we're making progress in figuring out how we will piece it all together.

MIHP/WIC Integration WG: Discussed above (page 3).

MIHP Depression WG: Brenda will form an MIHP Workgroup to address perinatal depression because it is so prevalent among Medicaid beneficiaries and addressing it will require cross-systems collaboration. The Depression Workgroup will include subject matter experts who will assist the MFMP staff to identify evidence-based interventions, develop guidelines for referring women to mental health services, and formulate protocols for assisting women with depression when specialty mental health services are not available. Some MIHP women will be eligible for community mental health services because they meet the definition of severe and persistently mental ill, but most will not.

Jackie Wood said that the Child Death Review Program has been seeing more depression in child death reviews, and that program staff at MPHI may be helpful in this regard.

Mary said that Depression Workgroup could also draw upon the expertise of individuals who have been involved with development of a state plan for "Addressing Depression as a Public Health Concern in Michigan." Carol Callaghan, MDCH Division of Chronic Disease and Injury Control, funded the development of an initial plan this summer. Four workgroups were convened: Prenatal to Five Years, Six to Eighteen Years, Adults and Older Adults. Brenda said that three big populations that were identified as priorities are moms, teens and older adults. Brenda is meeting soon with Carol to discuss coordinating efforts on perinatal depression and adolescent suicide. Members of the perinatal depression subgroup of the Prenatal to Five Years Workgroup have volunteered to serve on the MIHP Depression Workgroup, if invited. Deb noted that the Maternal Child Health Bureau is planning to issue an RFP for state perinatal depression grants in January, "if the money is there." Lynette said this would be the last round for this grant program. Mary would like to know the percentage of MIHP women with depression who also have other mental health disorders.

Other Quick MIHP Updates

Infant Screener: Lynette said the infant screener is coming soon and will be on the agenda for our November DWG meeting. Developing the infant screener is much more complex and could end up being much longer than the maternal screener. Lynette will have the infant screener draft to the DWG next week, and it will be posted on the web site soon thereafter.

Development of MIHP Intervention: MFMP staff has been doing a great deal of background work collecting citations on interventions. The MIHP Steering Committee

developed a quarterly schedule in which the matrix interventions are addressed a few at a time, so that they're easier to digest. Ingrid noted that DCH has set aside resources for two more trainings on interventions in FY 06 if we need them.

Visit to Illinois DHS Family Case Management and WIC Programs: Ingrid reported on the Aug. 25 site visit that she, Jackie Prokop, and Diane Revitte made to the Illinois DHS in Chicago to observe their Family Case Management (FCM) and WIC Programs. Some highlights:

- Ingrid, Jackie and Diane visited two sites: one in which FCM and WIC were integrated and one in which they were not.
- Case managers carry average caseloads of 150-200 women; caseloads of 30-50 if the women are high risk. High-risk women are visited more frequently (by a nurse).
- Pregnant women are seen every trimester if they have no major problems and services continue until the infant is 12 months old.
- They don't serve the highest-risk women after the baby is born. At that point, the family is referred to Healthy Start or another program.
- Case managers are nurses, social workers and nutritionists. They don't use parapros for screening.
- In general, case managers provide referrals and follow-up, not professional interventions. Chicago has an extensive neighborhood/community organization network. However, if there's no place to refer a woman, they "do the best they can."
- Their data system (Cornerstone) is key, although it's outdated and not web-based. Case managers have to go back to the office after a home visit to enter the data, which takes about an hour. Then they get a printout of objectives for interventions. They don't have a central registry. Periodically the state requests data from the providers and they pull it together. They're slowly moving to a web-based system.
- In Chicago, they bring WIC providers, FCM management providers, and others together for monthly cluster meetings to discuss current issues, which works well to promote collaboration.
- The program is largely supported with Medicaid administrative match funds. In Illinois, the state-federal match is 50-50 for both administrative and direct services. In Michigan, we have to spend more general funds on administrative match than on direct services match.
- They have a case rate reimbursement system. Providers get a monthly rate based on the women they are serving.
- Fifteen years ago they got $40 million to operate the program and they're still getting the same amount. They wish they had built increases into the case rate, as they are built into fee-for-service.
- They use WIC as a carrot, but they still have outreach issues.
- The system in Chicago is different from the system out-state.
- It was very worthwhile to learn about the Illinois model, but there are some big differences between Illinois and Michigan.

Sharifa Aboumediene, ACCESS, indicated that she joined the call late. She said that depression is a big issue for their MIHP women in her community and that ACCESS would like to be in on the MIHP/WIC discussions that are being held in Southeast Michigan.

Key MIHP Program Development Activities for FY 06: Jackie Prokop distributed copies of the next version of *Key MIHP Program Activities for FY 06*, which was drafted by the Steering Committee. Activities are broken out by quarters. A more detailed version should be available before the next DWG meeting.